Submit

WYOMING DEPARTMENT OF HEALTH
COMMUNICABLE DISEASE UNIT PRIOR AUTHORIZATION REQUEST FORM

- ✓ **This form must be filled out and authorized by WDH prior to the patient receiving services.**
- ✓ **Please give the authorized form to the patient to take with them and present to staff at the time of service.**
- ✓ **Prior authorization approvals or denials will be processed within 48-72 business hours.**

Chest X-Rays, Liver Function tests and IGRAs will only be paid at the current Medicaid rate or the actual billed fee, whichever is less:

CPT	Name	Critical Access (CA)	General (GA)	Children's (CH)	Practitioner (PP)	WY Public Health Lab	ND Public Health Lab
71010	X-Ray Single	$83.02	$32.63	$70.36	$11.65		
71020	X-Ray Double	$83.02	$32.63	$70.36	$15.76		
36415	Venipuncture	$2.70	$2.70	$2.70	$2.70		
80076	Liver Function Panel	$9.67	$9.67	$9.67	$9.67		
71010.26	Single-Rad. Fee				$6.51		
71020.26	Double-Rad. Fee				$7.88		
	IGRA	$77.93	$77.93	$77.93	$77.93	$40.00	
	Hepatitis C (HCV) RNA						$55.00

Today's date:	Proposed date of service:	
Patient First Name:	Patient Last Name:	Patient DOB:
Facility Requesting Service:	Ordering Provider:	Facility Contact Person:
Facility Phone:	Facility Fax:	Contact Person's Email:
Services Requested		
Chest X-Ray (Select One)	☐ Liver Function Test	Interferon Gamma Release Assay (IGRA) – (**Denote Lab Below)**
☐ One-View (Single)	☐ HCV RNA Test	☐ WPHL
☐ Two-View (Double)		☐ Other: _____
Comments/Other:		

Wyoming Department of Health TB Program is payer of last resort. Please denote clients' insurance status:			
☐ Insurance	☐ Medicare or Medicaid	☐ Under-insured	☐ Uninsured

INTERNAL USE ONLY

____ Request Approved Authorization #: _____
____ Request Denied Reason:_____

Program Signature/Date: _____

Please send Health Insurance Claim form for payment to:
Wyoming Department of Health, Communicable Disease Unit
6101 Yellowstone Road, Suite 510
Cheyenne, WY 82002
Phone: 307-777-3562 Fax: 307-777-5279